COMMUNITY CONSOLIDATED SCHOOL DISTRICT 64 Park Ridge-Niles

164 S. Prospect Avenue Park Ridge, IL 60068-4079 (847) 318-4300 FAX: (847) 318-4351

INSULIN AUTHORIZATION FORM

Student's Name: _____ Birth Date: _____
Address: _____ Telephone: _____
School: _____ Grade/Room: _____ Teacher: _____

To be completed by the child's physician, physician assistant, or advanced practice registered nurse:

Physician's/Health Care Provider's Printed Name: _____
Office Address: _____
Office Phone: _____ Emergency Phone: _____

Is it necessary for INSULIN to be administered during the school day? ___Yes ___ No
Diagnosis of Student Requiring Insulin: _____
Dose: _____ Frequency: _____
Time When Insulin Is To Be Administered _____
Possible Expected Side Effects: _____
Other Medications Student Is Receiving: _____
Prescription Date: _____ Order Date: _____ Discontinuation Date: _____

_____ _____
Physician Signature **Date**

To be completed by the child's parent/guardian:

I hereby authorize the Park Ridge-Niles Community Consolidated School District No. 64 ("School District 64") and its employees and agents to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State law, while under the supervision of the employees and agents of the School District), insulin, a lawfully prescribed medication, in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices and I agree to indemnify and hold harmless School District 64 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication. Pursuant to Section 45 of the Care of Students with Diabetes Act, I acknowledge that School District 64 and its employees are not liable for civil or other damages as a result of conduct, other than willful or wanton misconduct, related to the care of a student with diabetes.

_____
Parents/Guardian's Printed Names

_____ _____
Parent/Guardian Signature **Date**